Childhood Well-care Assessment
18 months to 12 years

Amerigroup RealSolutions in healthcare

Name: **Date:**

DOB: **Sex:**

Wt: **Ht:** **BMI:** **T:** **BP:**

Interval history

Medications:

Allergies:

Illnesses/accidents/problems/concerns:

Diet: **Sleep:**

Elimination: **Other:**

Review immunization record	❒	WIC referral	❒	Vitamins	❒
Review of systems	❒	Review of family history	❒	Lead-risk assessment	❒
Dental referral	❒	Fluoride supplements	❒	Tb test (if high risk)	❒

Screening	Normal/abnormal		Normal/abnormal		Normal/abnormal	
Hearing	❒	❒	Vision	❒ ❒	Development	❒ ❒
Behavior	❒	❒	Emotional	❒ ❒	Communication	❒ ❒

Physical exam	Normal/abnormal		Normal/abnormal		Normal/abnormal	
General appearance	❒	❒	Lungs	❒ ❒	Skin	❒ ❒
Reflexes	❒	❒	Chest	❒ ❒	Head/fontanel	❒ ❒
Ears	❒	❒	Nose/throat	❒ ❒	Eyes	❒ ❒
Teeth	❒	❒	Neurological	❒ ❒	Abdomen	❒ ❒
Spine	❒	❒	Extremities	❒ ❒	Genitalia	❒ ❒

If abnormal, explain:

Health education/anticipatory guidance

❒	Nutrition	❒	Regular physical activities	❒	Passive smoke
❒	Appropriate car seat/seat belt	❒	Language development	❒	Oral health
❒	Developmental	❒	School issues	❒	Child care issues
❒	Injury prevention	❒	Supervision/safety	❒	Other _____

Notes/plans:

Next visit: **Provider signature:**